

Exhibit C



February 20, 2015

JOHN RAKIS
C/O MICHAEL BARASCH
BARASCH MCGARRY SALZMAN & PENSON
11 PARK PLACE 1801
NEW YORK NY 10007-2811

Dear John Rakis:

The Special Master has determined that you have been appointed as the Personal Representative for the claim filed on behalf of **FREDDIE WALLACE-RAKIS** and the September 11th Victim Compensation Fund ("VCF") will move forward with the review of your claim. The claim number is **VCF0026520**.

As the Personal Representative, you are responsible for submitting all materials necessary for the VCF to process the claim. This includes information and documents needed to determine the decedent's eligibility and to calculate the appropriate compensation under the terms of the Statute and Regulations.¹

The Personal Representative is also responsible for assuring that any compensation received from the VCF on behalf of the deceased individual is distributed to the eligible survivors or other recipients in accordance with the applicable state law or any applicable ruling made by a court of competent jurisdiction or as provided by the Special Master. Please see Frequently Asked Questions ("FAQs") #5.1 - #5.5 and #8.11 on the www.vcf.gov website for more information.

When submitting the Compensation Form for Deceased Individuals, you are required to propose a distribution plan. If there is a bona fide dispute over the proposed distribution plan, the Special Master is not required to arbitrate, litigate, or otherwise resolve any such dispute. In these situations, the Special Master will, if sufficient information is provided, calculate the appropriate compensation amount and authorize payment, but will hold any payment until the dispute is resolved. If the dispute cannot be resolved by agreement of the various parties, the Special Master may deposit the award into your account (as the Personal Representative) or into a court supervised account while the dispute is adjudicated by a court of competent jurisdiction.

The VCF will inform you if any additional documentation is needed in order to process your claim.

If you have any questions regarding your claim, please call the VCF toll-free Helpline at 1-855-885-1555. For the hearing impaired, please call 1-855-885-1558 (TDD). If you are calling from outside the United States, please call 1-202-514-1100. Every effort will be made to respond to your application and/or inquiries as soon as possible.

¹ The Statute (the Air Transportation Safety and System Stabilization Act as amended by the Zadroga Act) and the Regulations are located at <http://www.vcf.gov/genProgramInfo.html>.



July 9, 2018

JOHN RAKIS
C/O MICHAEL BARASCH
BARASCH MCGARRY SALZMAN & PENSON
11 PARK PLACE 1801
NEW YORK NY 10007-2811

Dear JOHN RAKIS:

The September 11th Victim Compensation Fund ("VCF") sent you a letter on February 22, 2018 notifying you of the decision on your claim and the amount of your award. Your claim number is **VCF0026520**. That letter included a request for documents that were missing from your claim and are required in order to process your payment. The VCF has since received the requested documents and this letter provides the details of your award and information on the next steps to be taken on your claim.

Based on the information you submitted, the VCF has calculated the amount of your eligible loss as **\$462,750.19**. This determination is in accordance with the requirements of the Reauthorized Zadroga Act. The enclosed "Award Detail" includes a detailed explanation of the calculation and a list of the eligible conditions included in this determination.

No non-routine legal service expenses are approved for reimbursement for this claim.

As the Personal Representative, you are required to distribute any payment received from the VCF on behalf of the victim to the eligible survivors or other recipients in accordance with the applicable state law or any applicable ruling made by a court of competent jurisdiction or as provided by the Special Master.

What Happens Next

The VCF will deem this award to be final and will begin processing the payment on your claim unless you complete and return the enclosed Compensation Appeal Request Form within **30 days from the date of this letter** as explained below. If you do not appeal, the Special Master will authorize the payment on your claim within 20 days of the end of the 30-day appeal period. Once the Special Master has authorized the payment, it may take up to three weeks for the United States Treasury to disburse the money into the bank account designated on the VCF ACH Payment Information Form or other payment authorization document you submitted to the VCF.

- **Appealing the Award:** You may request a hearing before the Special Master or her designee if you believe the amount of your award was erroneously calculated or if you believe you can demonstrate extraordinary circumstances indicating that the award does not adequately address your claim. **If you choose to appeal, your payment will not be processed until your appeal has been decided.**



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Victim Compensation Fund

To request a hearing, you must complete and return the enclosed Compensation Appeal Request Form and Pre-Hearing Questionnaire no later than **30 calendar days** from the date of this letter. The VCF will notify you in writing of your scheduled hearing date and time and will provide additional instructions to prepare for your hearing. If both forms are not submitted with complete information within 30 days, you have waived your right to appeal and we will begin processing your payment.

- **Amending your Claim:** You may amend your claim in the future if your circumstances change and you have new information to provide to the VCF. For example, you may amend if the WTC Health Program certifies additional physical conditions for treatment, if you have information in support of your claim that was not submitted to the VCF when your award was determined and that you believe would affect the amount of your award, or if you have incurred additional economic loss due to an eligible condition. The VCF will review the new information and determine if it provides the basis for a revised decision. Please see the VCF website for additional details on how to amend your claim and the specific circumstances that may be appropriate to request an amendment.
- **Notifying the VCF of new Collateral Source Payments:** You must inform the VCF of any new collateral source payments you receive, or become entitled to receive, such as a change to your disability or survivor benefits, as this may change the amount of your award. If you notify the VCF within 90 days of learning of the new collateral source payment, your award will not be adjusted to reflect the new entitlement or payment. If you notify the VCF more than 90 days after learning of the new or revised entitlement or payment, the VCF may adjust your award to reflect the new payment as an offset, which may result in a lower award. If you need to notify the VCF of a new collateral source payment, please complete the "Collateral Offset Update Form" found under "Forms and Resources" on the www.vcf.gov website.

Your award was calculated using our published regulations, and I believe it is fair and reasonable under the requirements of the Reauthorized Zadroga Act. As always, I emphasize that no amount of money can alleviate the losses suffered on September 11, 2001.

If you have any questions, please call our toll-free Helpline at 1-855-885-1555. For the hearing impaired, please call 1-855-885-1558 (TDD). If you are calling from outside the United States, please call 1-202-514-1100.

Sincerely,

Rupa Bhattacharyya
Special Master
September 11th Victim Compensation Fund

cc: JOHN RAKIS



September 11th
Victim Compensation Fund

Award Detail

Claim Number: VCF0026520
Decedent Name: FREDDIE WALLACE-RAKIS

PERSONAL INJURY CLAIM (Losses up to Date of Death)	
Lost Earnings and Benefits	
Loss of Earnings including Benefits and Pension	
Mitigating or Residual Earnings	
Total Lost Earnings and Benefits	\$0.00
Offsets Applicable to Lost Earnings and Benefits	
Disability Pension	
Social Security Disability Benefits	
Workers Compensation Disability Benefits	
Disability Insurance	
Other Offsets related to Earnings	
Total Offsets Applicable to Lost Earnings	\$0.00
Total Lost Earnings and Benefits Awarded	\$0.00
Other Economic Losses	
Medical Expense Loss	
Replacement Services	
Total Other Economic Losses	\$0.00
Total Economic Loss	\$0.00
Total Non-Economic Loss	\$250,000.00
Subtotal Award for Personal Injury Claim	\$250,000.00



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DECEASED CLAIM (Losses from Date of Death)

Loss of Earnings including Benefits and Pension	
Offsets Applicable to Lost Earnings and Benefits	
Survivor Pension	
SSA Survivor Benefits	
Worker's Compensation Death Benefits	
Other Offsets related to Earnings	
Total Offsets Applicable to Loss of Earnings and Benefits	\$0.00
Total Lost Earnings and Benefits Awarded	\$0.00
Other Economic Losses	
Replacement Services	
Burial Costs	\$20,705.00
Total Other Economic Losses	\$20,705.00
Total Economic Loss	\$20,705.00
Non-Economic Loss	
Non-Economic Loss - Decedent	\$250,000.00
Non-Economic Loss - Dependent(s)	\$100,000.00
Total Non-Economic Loss	\$350,000.00
Additional Offsets	
Social Security Death Benefits	(\$255.00)
Life Insurance	(\$61,254.89)
Other Offsets	(\$96,444.92)
Total Additional Offsets	(\$157,954.81)
Subtotal Award for Deceased Claim	\$212,750.19



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Subtotal of Personal Injury and Deceased Claims	\$462,750.19
PSOB Offset	
Prior Lawsuit Settlement Offset	
Previously Paid Personal Injury Award	
TOTAL AWARD	\$462,750.19
Factors Underlying Economic Loss Calculation	
Annual Earnings Basis (without benefits)	
Percentage of Disability attributed to Eligible Conditions - applicable to Personal Injury losses	
Start Date of Loss of Earnings Due to Disability - applicable to Personal Injury losses	

Eligible Conditions Considered in Award
Acute Myelogenous Leukemia



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Treating Physician Information Form

Treating Physician Information Form

Name of Patient: Freddie Wallace-Rakis

VCF Claim Number: VCF 0026520

Physician Name: Elpidio Jimenez, M.D.

In the below chart, list the conditions for which you are currently treating (or previously treated) the Claimant. For each condition, provide the earliest date (month and year) of symptom onset and the date of first diagnosis (month and year).

Please provide copies of relevant records to support the diagnoses for the conditions listed below and any other information that might be relevant to the VCF, such as the effect of the condition(s) on the Claimant. As an alternative to providing supporting medical records, you may instead provide a written report explaining your diagnosis and its basis, along with your recommendation for treatment and management.

If applicable, please also provide a summary of any complications of treatment (i.e., new diagnoses stemming from treatment) and provide applicable medical records.

Condition Treated	Earliest Date of Symptom Onset (month/year)	Date of First Diagnosis (month/year)
Acute Leukemia		12/31/12



FREDDIE WALLACE-RAKIS

DOB: [REDACTED]

12:00:00AM

MR#: [REDACTED]

EKG 12 lead EKG[Reference:EEKG6755651]<Kristie Busch DO Dec 27 2012 4:57PM>

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PMD Dr Lwin [Reference:CPMD6755651]<Kristie Busch DO Dec 27 2012 5:32PM>

ORDERED BY LAB

Urine Microscopic[Reference:SQH270681UMIC]<BUSCH, KRISTIE A Dec 27 2012 6:45PM>



FREDDIE WALLACE-RAKIS	DOB:	12:00:00AM	MR#:	
Results				

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BASERecover

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MICRO Tests Results Date Jan 2 2013 5:14PM	Test Blood Culture	Order Date
Blood Culture	-	
Blood Culture	Spec. Descr. BLOOD	
Blood Culture	Gram Stain gram positive cocci in pairs and chains in the	
Blood Culture	anaerobic bottle.	
Blood Culture	Culture Enterococcus faecium For susceptibility results, see	
Blood Culture	order W286068	
Blood Culture	BETH ISRAEL PETRIE DIV FIRST AVE AT 16TH ST., NEW	
Blood Culture	YORK, NEW YORK 10003	
Blood Culture	-	
Blood Culture	Report Status 01/05/2013 Final	
MICRO Tests Results Date Jan 2 2013 5:18PM	Test Blood Culture	Order Date
Blood Culture	-	
Blood Culture	Spec. Descr. BLOOD	
Blood Culture	Gram Stain gram positive cocci in pairs and chains in the	
Blood Culture	anaerobic bottle.	
Blood Culture	Culture Enterococcus faecium	
Blood Culture	BETH ISRAEL PETRIE DIV FIRST AVE AT 16TH ST., NEW	
Blood Culture	YORK, NEW YORK 10003	
Blood Culture	-	
Blood Culture	Report Status 01/05/2013 Final	
Pathology Tests Results Date Dec 31 2012 3:36PM	Test PATH	Order Date
PATH	CASE: LS12-12095	12/31/2012
PATH	PATIENT: FREDIE WALLACE-RAKIS	
PATH	TISSUE SUBMITTED: A. BONE MARROW CORE BX	
PATH	B. BONE MARROW CLOT BX	
PATH	C. 1 SMEAR	
PATH	FINAL DIAGNOSIS:	
PATH	A. B. and C. Bone marrow core biopsy, clot and smear:	
PATH	Acute myelogenous leukemia.	
PATH	Favor acute monocytic leukemia.	
PATH	Note: bone marrow biopsy and clot show markedly hypercellular bone marrow with marked increase in the number of nucleated cells to be blast forms and promonocytes.	
PATH	PATH The flow cytometry analysis of peripheral blood performed at Integrated	
PATH	Oncology was reported as showing approx. 20% myeloblasts. The myeloblasts show the following phenotype: positive for CD13, CD33, CD34, CD117, HLA-DR, CD11c	
PATH	CD14, CD34. An increased number of CD14+/CD64+ monocytes ("15% of total) were also reported.	
PATH	CLINICAL HISTORY:	
PATH	Acute leukemia	
PATH	GROSS:	
PATH	A. The specimen is received in formalin and labeled "Bone Marrow Biopsy". It	
PATH	consists of a 1.0 x 0.2 cm core of tan-red bone tissue. Entirely submitted in	
PATH	one cassette.	
PATH	B. The specimen is received in formalin and labeled "Bone Marrow Clot". It	
PATH	consists of a 2.2 x 1.8 x 0.2 cm aggregate of blood clots. Entirely submitted	
PATH	in one cassette.	
PATH	C. The specimen consists of one bone marrow smear. The slide is sent to	
PATH	Hematology for staining.	
PATH	Dictated by G2.	
PATH	The electronic signature indicates that the named Attending Pathologist has	
PATH	evaluated the specimen referred to in the signed section of the report and	
PATH	formulated the diagnosis therein.	
	Electronically signed by Elpidio Jimenez, M.D. 12/31/2012 3:34:52PM	
Radiology Tests Results Date Dec 27 2012 5:20PM	Test Xray Chest (PA/Lat)	Order Date
Xray Chest (PA/Lat)	I, Ira Reznick, M.D., have personally reviewed the images and concur	12/27/2012
Xray Chest (PA/Lat)	with the preliminary report below. This report now represents the	
Xray Chest (PA/Lat)	FINAL REPORT for this patient.	
Xray Chest (PA/Lat)	

Mar 28 2017 12:53PM HP LASERJET FAX

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DATE FILED THE CITY OF NEW YORK - DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH Certificate No.

THE CITY OF NEW YORK - DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CONFIDENTIAL MEDICAL REPORT

CONFIDENTIAL MEDICAL REPORT		Certificate No. _____	
<p>To be filled in by FUNERAL DIRECTOR or, in case of City Burial, by Physician</p> <p>26. Ancestry (Check one box and list) <input checked="" type="checkbox"/> 26. Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.) <input type="checkbox"/> 27. Asian (Chinese, Japanese, Korean, Vietnamese, etc.) <input type="checkbox"/> 28. Black or African American <input type="checkbox"/> 29. Canadian Indian or Alaska Native <input type="checkbox"/> 30. American Indian or Alaskan Native <input type="checkbox"/> 31. Asian Indian <input type="checkbox"/> 32. Chinese <input type="checkbox"/> 33. Japanese <input type="checkbox"/> 34. Vietnamese <input type="checkbox"/> 35. Other Asian-Specific <input type="checkbox"/> 36. Canadian or Alaskan Native <input type="checkbox"/> 37. Greenlandic or Inuit <input type="checkbox"/> 38. Other Pacific Islander-Specific <input type="checkbox"/> 39. Other-Specific</p>		<p>26. Place of birth by the U.S. Census (Check one or more to indicate where deceased considered himself or herself in the U.S.) <input type="checkbox"/> 21. White <input type="checkbox"/> 22. Black or African American <input type="checkbox"/> 23. American Indian or Alaska Native <input type="checkbox"/> 24. Asian Indian or Alaskan Native <input type="checkbox"/> 25. Chinese <input type="checkbox"/> 26. Japanese <input type="checkbox"/> 27. Vietnamese <input type="checkbox"/> 28. Other Asian-Specific <input type="checkbox"/> 29. Canadian or Alaskan Native <input type="checkbox"/> 30. Greenlandic or Inuit <input type="checkbox"/> 31. Pacific Islander-Specific <input type="checkbox"/> 32. Other-Specific</p>	
<p>27. GENDER: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>28. RELATIONSHIP TO DECEASED: <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Cousin <input type="checkbox"/> Niece <input type="checkbox"/> Nephew <input type="checkbox"/> Other (Specify) _____</p>		<p>29. DECEASED'S LEGAL NAME (Type or Print) FREDDIE WALLACE RAJAS</p>	
<p>30. CAUSE OF DEATH - List only one cause in each box. DO NOT ABBREVIATE.</p> <p>A. IMMEDIATE CAUSE <input checked="" type="checkbox"/> 30.1. Acute Hypertension</p> <p>B. DUE TO OR AS A CONSEQUENCE OF</p> <p>C. DUE TO OR AS A CONSEQUENCE OF</p> <p>D. DUE TO OR AS A CONSEQUENCE OF</p>		<p>31. APPROXIMATE DATE OF DEATH <input checked="" type="checkbox"/> 31.1. 2010</p>	
<p>32. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH - List any contributing conditions in the preceding cause given in Part I. Include operation information.</p> <p>Renal Failure Hypertension</p> <p>33. Was an autopsy performed? <input checked="" type="checkbox"/> 33.1. Yes <input type="checkbox"/> 33.2. No</p> <p>34. When autopsy findings were made, did they contribute to the cause of death? <input type="checkbox"/> 34.1. Yes <input checked="" type="checkbox"/> 34.2. No</p> <p>35. Did the deceased use controlled substances to death? <input type="checkbox"/> 35.1. Yes <input checked="" type="checkbox"/> 35.2. No <input type="checkbox"/> 35.3. Partially <input type="checkbox"/> 35.4. Unknown</p>		<p>36. Postmortem vital signs of deceased, outcome of pregnancy <input type="checkbox"/> 36.1. Dead stillborn <input type="checkbox"/> 36.2. Stillborn Termination <input type="checkbox"/> 36.3. Infected Termination <input type="checkbox"/> 36.4. None</p> <p>37. Date of death <input type="checkbox"/> 37.1. 2010</p>	
<p>38. Was this note referred to OCM? <input type="checkbox"/> 38.1. Yes <input checked="" type="checkbox"/> 38.2. No</p>		<p>39. Signature _____ Date _____</p>	
<p>I am enclosing a copy of a confidential report of the cause of death.</p> <p><i>Freddie Wallace Rajas</i> Freddie Wallace Rajas <input type="checkbox"/> MD</p>		<p>40. For Infant under one year: Name and address of hospital or other place of birth.</p> <p>ADDRESS: 339 Hicks Street, Brooklyn, New York 11201 LICENSE NO. 105457</p>	